



CHESAPEAKE CARE FREE CLINIC LICENSED VOLUNTEER APPLICATION

DATE: _____ VOLUNTEER POSITION: _____

NAME: _____
(last) (first) (middle)

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER'S NAME: _____

WORK ADDRESS: _____

HOME PHONE: () - _____ WORK PHONE: () - _____

CELLULAR: () - _____ PAGER: () - _____

E-MAIL ADDRESS: _____

Date of birth: mm/dd _____ Easiest way to contact you: _____

1. How did you learn about the Chesapeake Care Free Clinic? _____

2. Are you active military? Yes / No 3. Do you file a Virginia State Tax return? Yes / No

4. Professional License: (Circle) MD - DO - DDS - RN - NP - PA - LPN

License Number: _____ State Licensed: _____

5. Your preferred volunteer times: (Circle)

Monday AM - Monday Afternoon - Monday PM

Tuesday AM - Tuesday Afternoon - Tuesday PM

Wednesday AM - Wednesday Afternoon - Wednesday PM

Thursday AM - Thursday Afternoon - Thursday PM

Friday AM - Saturday AM

Other: _____

6. If you have a professional license, you are protected from liability if you are practicing within the scope of your license without compensation at a free clinic. You can only be sued for willful negligence. In order to establish this protection, WE MUST HAVE A COPY OF YOUR CURRENT LICENSE ON FILE. Be advised that Universal Precautions must be followed for all patient contact.

I understand the above _____ Date: _____